

## **HEPATITIS C ENROLLMENT & PRESCRIPTION FORM**

**PHONE**: 800-641-8475 **FAX**: 800-530-8589 **WEB**: www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

	Patient:			Caregiver:					
ź	DOB: Male	Female Weight: kgs o	r Ibs (check one) Heigh	nt: in or cm (check one)	Recorded Date	e:			
3	Address:		City:	State: _	Zip	):			
	Best Phone #:	Cell Alternate Ph	Cell Email:						
	Allergies:			_ Latex Allerg	ıy: Yes No				
	ICD-10 Code for requested therapy: ICD-10 Code(s) for other medical conditions:								
F	PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION								
ı	Diagnosis Date:			Failed therapy (list):					
	Genotype: 1 2 3	4 5 6 Subtype: A							
	Baseline viral load:	Date	:						
	Degree of fibrosis: F0	F1 F2 F3 F4							
	Cirrhosis: None Comp	ensated Decompensated (CTP:	: B C)	Transplant status: N/A Pre-transplant Post-transplant sCr: Date:					
	Treatment naïve Treatm	nent experienced							
	Prior treatment (list):			CKD stage: 1 2 3 4 5	N/A Dialysi	s: Yes No			
				IL28B polymorphism: CC CT	TT				
				Q80K polymorphism: Yes No					
				NS5A polymorphism: Yes No					
ı					Q30 L31	Y93			
L		PLEASE PROVIDE ALL CLINICAL	INFORMATION INCLUID	ING LAB RESULTS ON ALL FORMS					
						DEFILE			
F	MEDICATION	DOSE/STRENGTH	D	IRECTIONS	QUANTITY	REFILLS			
(	Epclusa® (sofosbuvir/velpatasvir)	400 mg sofosbuvir/100 mg velpalasvir per tablet	Take one tablet once daily	28 day supply	Total Therapy: 12 weeks				
	Harvoni®	90 mg ledipasvir/400 mg	Take orally once daily with or without food.		28 day supply	Total Therapy: 8 weeks			
	(ledipasvir/sofosbuvir)	sofosbuvir per tablet	Do not take within 4 hours	12 weeks					
		45/200 (only for brand name)			24 weeks	24 weeks			
l		90/200	Take orally once daily with or without food.  Do not take within 4 hours of antacids.		28 day supply	Total Therapy:			
	Lepidasvir/Sofosbuvir (generic for Harvoni)					8 weeks 12 weeks			
ı	(generic for Harvorii)					24 weeks			
ŀ									
1	Mavyret	100/40	O tablete and time delta with food		28 day	Total Therapy:			
	(Glecaprevir/Pibrentasvir)	100/40	3 tablets one time daily wit	(II 1000	supply	8 weeks 12 weeks			
L		200 ma tableta							
ı		200 mg tablets 200mg capsules							
l	Ribavirin (Ribasphere®)	200 mg tablets		orally q am and tabs/caps q	28 day				
ĺ		400 mg tablets	pm for a total of	_mg daily	supply				
		600 mg tablets							
Ì		600/600 mg							
l	Ribasphere® RibaPak®	600/400 mg	Take mg orally	28 day					
		400/400 mg	a total of mg daily supply						
		200/400 mg							
	Sofosbuvir/Velpatasvir	. A00/100 I 1 tablet daily with or without tood			28 day	Total Therapy:			
L	(generic for Eplcusa)	TOU/ 100	r tablet daily with or withou	ut 100u.	supply	12 weeks			
	Sovaldi® (sofosbuvir)	400 mg tablets	Take one 400 mg tablet or	28 day supply					
		250mg Dasabuvir/			Total Theren				
	Viekira Pak™ (Dasabuvir Oral tablet/Ombitasvir/	12.5mg Ombitasvir/		asvir, paritaprevir, ritonavir) once daily let (dasbuvir) twice daily (morning and	28 day	Total Therapy: 12 weeks			
	Paritaprevir/Ritonavir)	75mg Paritaprevir/50mg	evening) with meals.	to (account) twice daily (morning and	supply	24 weeks			



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	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PRESCRIPTION INFORMATION	Vosevi (Sofosbuvir/Velpatasvir/ Voxilaprevir)	400/100/100	1 tablet daily with food. Do not take within 4 hours of antacids containing AL or Mag.	28 day supply	Total Therapy: 12 weeks
	Zepatier™ (elbasvir/grazoprevir)	50 mg elbasvir/100 mg grazoprevir per tablet	Take one tablet daily with or without food	28 day supply	Total Therapy: 12 weeks 16 weeks
	Other				

		INJECT	ION TRAINING:		OFFICE TO COOR	DINATE	WELLDYNE SPECIALTY TO COORDINA	TE
_	Anticipated Start Date:		Prescriber Specialty:					
IOIL	Ship to:	Patient	Physician	Clinic	Other:			
RMA	Fax #:		Contact Name:					
INFORM,	Office Address:				City:	State:	Zip:	
Ν	The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.							
IBE	The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.							
SCR	I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.							
PRESCRIBER	Prescribe	r's Name:			Presc	riber's Signature: _		Date:
а.	Use su	bstitution	Dispense as wr	itten				

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